

# GALAVAN APPLICANT INTAKE FORM

Your answers to these questions do not affect your eligibility criteria for Galavan services. This data is collected for HRDC's internal statistics and reporting to funding sources. Your thoroughness is greatly appreciated!

Name \_\_\_\_\_ Date \_\_\_\_\_  
Phone \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_  
Street Address \_\_\_\_\_ Zip \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Zip \_\_\_\_\_  
Emergency Contact/Phone \_\_\_\_\_

Gender:  M  F Hispanic/Latino:  Y  N Veteran:  Y  N Disabled:  Y  N  
Race:  White  American Indian/Native Alaskan  Black/African American  Asian  
 Native Hawaiian/Other Pacific Islander  Biracial/Multi-racial  Other  
Health Insurance:  Medicaid  Medicare  Private  None

Do you use a:
<input type="checkbox"/> power chair
<input type="checkbox"/> wheelchair
<input type="checkbox"/> walker

Marital Status *Please select the option that best describes your marital status:*  
 Single  Domestic partner  Married  Separated  Divorced  Widowed

Family Type *Please select the option that best describes your family:*  
 Single person  Single parent – female  Single parent – male  
 Two parent household  Two or more adults (no children)  Grandparent(s) raising child(ren)  
 Mixed adults with children  Extended family  Other

Income Estimated gross household income: \$ \_\_\_\_\_ /  week  month  year (check one)

Employment Are you employed?  Yes  No  Retired  Unable to work (disabled receiving SSI/SSD)  
IF **NO**, do you have a positive work history and/or skills?  Yes  No  
If **Yes**, are you employed  Full-time (32+ hrs/wk)  Part-time  
If **Yes**, is your hourly wage  Minimum Wage  above Minimum Wage  
If **Yes**, does your employer provide benefits?  Yes  No

Housing Status *Please select the option that best describes your current living situation:*  
 Homeless  Substandard or unsafe housing  Living with relatives or friends (temporary)  
 Home ownership  Emergency/temporary shelter \_\_\_\_\_  Transitional housing \_\_\_\_\_  
 **Subsidized** unaffordable rental (facing eviction? )  **Non-Subsidized** unaffordable rental (facing eviction? )  
 Unaffordable home (facing foreclosure? )  **Subsidized** safe/secure housing  **Non-Subsidized** safe/secure housing  
*In addition....*  Are you using a **Section 8 Voucher** to pay rent?

Education Level *Please select your highest level of education:*  
 None  1<sup>st</sup>-8<sup>th</sup>  9<sup>th</sup>-12<sup>th</sup> non-graduate  GED  HS diploma  Vocational / certificate training / some college  
 College – Associates or Bachelors  College – Masters or Doctorate

Transportation *Please select the option that best describes your access to transportation:*  
 No vehicle or access to public transportation  Rarely have transportation needs met  
 Some transportation needs are met  Most transportation needs are met  Transportation needs are always met

Childcare *Please select the option that best describes your childcare situation:*  Not applicable  
Child/Children...  
 enrolled in *unlicensed* childcare  not enrolled in any childcare  on waiting list for childcare  
 provided childcare by family/friend  enrolled in licensed *subsidized* childcare – *limited choice*  
 enrolled in licensed *subsidized* childcare – *of own choice*  enrolled in licensed *non-subsidized* childcare – *of own choice*

I authorize HRDC IX, Inc. to enter the information contained on this application in electronic database(s) for purposes of tracking services provided to my household, and reporting to federal, state, or other funding sources.

Signature

Date

Intake by phone Intake completed by: \_\_\_\_\_ Client ID # \_\_\_\_\_  Head of Household  CAP#0 v3\_07182013

# Paratransit Application

## **1. Eligibility Questionnaire**

This form must be completed by the applicant or someone authorized to sign on the applicant's behalf.

## **2. Professional Verification Form**

All applicants must sign the Authorization for the Release of Information included in part 2, page 1. The rest of the form must be completed by a professional who is familiar with the applicant's condition and qualified to respond (see right).

## **3. Submit Both Forms Together**

Submit both the **Yellow Eligibility Application** and the **Green Professional Verification** together. All applications will be processed within 21 calendar days of receipt of the completed packet and the applicant will be notified in writing of Galavan's determination of eligibility.

## List of Qualified Professionals:

- Physician or Psychiatrist
- Physical Therapist
- Physician Assistant
- Licensed Clinical Social Worker (LCSW)(LCPC)
- Occupational Therapist
- Registered Nurse or Nurse Practitioner
- Psychologist
- Certified Orientation and Mobility Specialist
- Speech/Language Pathologist

*Galavan recognizes that many professionals work with clients that are disabled and the list above is not meant to exclude those professionals. In general, this will require completing a multi-year degree program and/or being licensed by the State of Montana. A primary care physician is often able to adequately complete this form. You do not need to visit a specialist.*

## Avoid Delays in Application Process

- All pages for both forms must be submitted
- Check that all questions have been answered
- Make sure all needed signatures are present
- Double check the professional credential section is complete

An incomplete application will be returned to the applicant one (1) time with a notice of what is missing. If it is returned to Galavan Paratransit incomplete a second time, the applicant will be sent a new blank application to complete.

## In-Person Assessment

The eligibility of most applicants can be determined by the forms submitted to Galavan staff. However, there may be cases where Galavan requests to conduct an in-person functional assessment of an applicant's disability. This assessment may include, but is not limited to:

- A conversation about the applicant's mobility
- Reading a bus schedule to plan out a bus trip
- Taking a short walk
- Practice boarding an actual bus

If an in-person assessment is requested, your application will still be processed within 21 calendar days of receipt. Transportation will be provided to an in-person assessment if necessary.

App Received: _____
Approved: _____
Expiration Date: _____

# 1 Part 1 Eligibility Application

Complete the entire application. Incomplete applications will be returned.

<b>Is this a new application, or a recertification?</b> <input type="checkbox"/> New <input type="checkbox"/> Recertification		
<b>Applicant Information</b>		
First Name	Last Name	Middle Initial
Street Address		Apt. #
City	State	Zip Code
Is this an apartment complex, mobile home park, or facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of complex or facility	
Home Phone	Mobile Phone	Email Address
Preferred Notification Method <input type="checkbox"/> Voice Call <input type="checkbox"/> Email	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Prefer not to say	
Date of Birth (mm/dd/yyyy)	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Other _____	

<input type="checkbox"/> <b>Check this box if someone other than the applicant is completing this form and provide the following information</b>		
<b>Legal Guardian Information</b>		
First Name	Last Name	Middle Initial
Street Address		Apartment #
City	State	Zip Code
Home Phone	Mobile Phone	Relationship to Applicant (Family Member, Case Worker, etc.)

<b>In case of emergency, who should we contact?</b>
Emergency Contact Name
Primary Phone ( )
Secondary Phone ( )
Relationship

<b>Who is authorized to contact Galavan on your behalf?</b>
Contact Name 1 (Individual or Organization)
Phone ( )
Contact Name 2 (Individual or Organization)
Phone ( )

## A General Information

How long would you like to use the service?  Temporarily  Permanently (Recertification is required every 2 years)

### What is your current primary transportation option?

- Walking  Taxi  Galavan Paratransit  
 Drive myself  Fixed Route Bus  Other, specify: \_\_\_\_\_  
 Ride with somebody  Bicycle

### Can you use the fixed route bus without someone else's help?

- Yes, I currently ride the Fixed Route Buses  No, I have never ridden.  
 I only ride with assistance from others.  I do not ride anymore because: \_\_\_\_\_  
 I only ride when the bus stops are accessible.

### Galavan provides free, in-person training to help you learn to ride our Fixed Route Buses. Would you be interested in this as an alternative?

- No  Yes  Possibly, please contact me.

### Do you require a Personal Care Attendant to travel with you?

- No  Yes  Sometimes, specify: \_\_\_\_\_

Do you travel with a Service Animal?  No  Yes, Type: \_\_\_\_\_

## B Required Assistance

**What mobility device(s) will you be using?** (Note: Larger mobility devices and devices that exceed 600 pounds when occupied may exceed equipment transport capacity.)

- Cane  White Cane  Manual Wheelchair  
 Crutches  Prosthesis  Powered Wheelchair or Scooter  
 Walker  Portable Oxygen  No aid required

What is your estimated bodyweight?  lbs.

**Are you able to complete the following tasks without assistance from another person?**

Check a box for each question. If you answer sometimes for any questions please explain.

A. Get to/from a bus stop?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
B. Walk or travel using a mobility device for 3 blocks?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
C. Get on/off a fixed route bus <b>without</b> using the lift or ramp?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
D. Get on/off a fixed route bus using the lift or ramp?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
E. Climb three 10-inch steps?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
F. Wait at a bus stop while standing for 15 minutes?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
G. Wait at a bus stop while sitting for 15 minutes?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
H. Maintain your balance entering, exiting, and riding a fixed route bus?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
I. Understand and follow verbal directions?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
J. Recognize correct stops and landmarks to complete a trip?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
K. Hear stops announced by the operator?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
L. Read and follow informational signs?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
M. Plan a trip using a bus schedule?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
N. Clearly communicate information about yourself?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes

Please explain any boxes checked Sometimes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## C Disability Information

*These questions help describe your disability and how it may impact you.*

What is your disability? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is your disability:

Permanent  Stable  Progressive  Temporary, how long? Months \_\_\_\_\_ Years \_\_\_\_\_

**Explain how your disability prevents you from the following:**

*Please provide a complete and specific answer. Attach an additional page if needed.*

- Getting on or off a lift/ramp equipped Fixed Route Bus; and/or
- Getting to or from a bus stop; and/or
- Successfully completing a bus trip

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**How far can you travel on level ground?** (With your mobility aid, if any.)

- Less than one block     Two blocks     Three blocks     Four blocks or more

**Can you, with a mobility aid if needed:**

- Self-ambulate from your threshold to curbside?     Yes     No  
Wait at the street curb for a ride?     Yes     No  
Wait at the front door/lobby for your ride?     Yes     No

(Note: Galavan operators are not allowed to cross the outer threshold of any residence, facility or business.)

**Does your disability prevent you from using Fixed Route service seasonally?**

- No, my inability to ride is not weather related.  
 Yes, I can only ride Fixed Route Buses in the summer.  
 Yes, I can only ride Fixed Route Buses in the winter.

**Does your disability change daily in ways that could disrupt your ability to use Fixed Route Bus service?**

- No     Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Please list three trips you frequently take:

Starting Address

Ending Address

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## **D** Application Signature

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I understand that the purpose of this application is to determine if the applicant is eligible to use ADA Paratransit Service. I certify that the information provided in this application is true and correct. **I understand that falsification of information could result in the denial of ADA Paratransit services as well as a penalty under the law.** I agree to notify Galavan if my circumstances change and I no longer need to use ADA Paratransit Services. I understand that I am responsible for authorizing a Professional Verification of my condition(s). I also understand that a follow-up conversation, an informational meeting or functional assessment by a professional selected by Galavan may be requested.

**Applicant or Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**The following pages must be sent to your Health Care Provider *after* you complete section 2, page 1, Information Release.**

Part **1** Completed.

# 2 Part 2 Galavan Paratransit Professional Verification

Complete the entire application. Incomplete applications will be returned.

## Information Release

### Medical Information / HIPAA Authorization

I, \_\_\_\_\_ authorize the healthcare provider (listed below), and their office completing this application to release to Galavan any protected health information about my disability in order to verify my eligibility for Paratransit service. I also authorize the release of further information should it be needed for this application for a period of 60 days from the date of my signature on this application unless revoked in writing.

_____	_____
Applicant Signature	Date
_____	_____
Applicant Name (printed)	Date of Birth
_____	_____
Applicant Address	Applicant Phone #

### Your Health Care Provider

Health Care Provider		
Provider	Profession	
Address	Phone	Fax

**The following pages must be filled out by your Health Care Provider.**



**Dear Healthcare Professional:**

The patient listed on the accompanying release form is applying for Galavan Paratransit Service. The information you provide in answering the questions on the enclosed questionnaire will aid Galavan in making a Paratransit eligibility determination. Please keep in mind this document is time sensitive. Because demand for this service is high, qualification criteria are stringent. For the benefit of the applicant please answer all of the questions completely and accurately. Please return completed questionnaires to the applicant so that they can return the completed packet to Galavan.

In accordance with Americans with Disabilities Act (ADA) guidelines, Paratransit service is available only for persons who have disabilities that prevent them from traveling on Fixed Route Buses. The individual could be prevented by inability to independently get to and from a bus stop, on or off a bus, or to successfully navigate to a destination.

Please keep in mind that ADA Paratransit eligibility is not based on age, a medical condition, the inability to drive, or the use of a particular mobility aid. The severity of a disability does not confer eligibility. Comfort and convenience are not factors. ADA Paratransit eligibility is based on the EFFECT that a disability has on your client's ability to use the regular Streamline lift or ramp equipped Fixed Route Bus system.

All information provided will remain confidential. If you have any questions, please call (406) 587-2434.

Thank you for your assistance,

**Galavan Paratransit Services**

## A General Disability Questions

Describe the diagnosed disability or disabilities that you are currently treating this individual for?

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Check all that apply

Is the patient's disability:

Permanent  Stable  Progressive  Temporary - How long? Months\_\_\_\_\_Years\_\_\_\_\_

Does your client's disability:

Affect mobility  Affect judgment  Require use of a mobility aid

Require them to have a PCA when traveling outside their residence (checking this box means that the client cannot travel safely without a PCA)

Can your client:

A. Walk two blocks (600 feet) with their mobility aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Climb three standard steps without assistance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Stand without support for 15 minutes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Walk or stand without debilitating pain or discomfort?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Board or de-board a fixed route bus equipped with a lift or ramp?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Recognize correct stops and landmarks to complete a trip?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G. Hear and understand verbal information?	<input type="checkbox"/> Yes <input type="checkbox"/> No
H. Read and understand informational signs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
I. Plan a trip using public transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
J. Communicate information about themselves?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## **B** Disability Specific Questions

ICD 11/DSM Code for the condition(s) you are treating: \_\_\_\_\_

WHODAS Score (if citing a cognitive or psychological disorder): \_\_\_\_\_

**Please only complete those questions that apply to the applicant for this section.**

Does the applicant experience seizures?  No  Yes

Is the applicant's judgment impaired?  No  Yes

Does this condition affect the applicant's ability to move independently outside their residence or a supervised environment?  No  Yes

Does the applicant experience any hallucinations, delusions, or disassociation?  No  Yes

Does this prevent the applicant from being oriented to person, place, & time?  No  Yes

**Please describe any triggers that may cause psychological disorders to manifest.**

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**Please describe the functional limitations caused by this impairment.**

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## **C** Mobility and Safety Questions

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**Does the applicant have a visual impairment that affects their ability to move about in the environment?**

No    Yes   If yes, please explain: \_\_\_\_\_

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**Has the applicant received any orientation & mobility training?**

No    Yes   If yes, please explain: \_\_\_\_\_

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**Please list any side effects of medication the applicant experiences that could affect transporting them safely.** \_\_\_\_\_

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**Would you like to add any additional comments on the functional ability of the applicant?**

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## D Provider Affirmation

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Provider Information		
Address	Phone	Fax
City	State	Zip code
Provider UPIN # or Tax ID	Employer / Agency	

### Provider Signature and Affirmation

I am a licensed medical provider or qualified service provider and certify that the above mentioned individual has the disability and limitations indicated above.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Name (printed)

Part **2** Completed.

# 3

Part 3 Galavan Paratransit

## Submit Both Forms Together

Complete the entire application. Incomplete applications will be returned.

**Make sure all questions have been answered, and required signatures are in place.**

Submit both the **YELLOW Eligibility Application** and the **GREEN Professional Verification Form**.

**Mail to:** Galavan Paratransit  
1812 N Rouse Ave  
Bozeman, MT 59715  
Fax #: (406) 582-7946

You may also submit all forms in person at the address above, M-F, 8:00 am – 5:00 pm.

All applications will be processed within 21 calendar days of receipt of a completed packet and the applicants will be notified in writing of Galavan’s determination of eligibility.

### In-Person Assessment

You will be contacted if an in-person assessment is required. If an in-person assessment is requested, your application will still be processed within 21 calendar days of receipt. Transportation will be provided to an in-person assessment if necessary.

**Thank you for completing the Paratransit Application. Please make sure that all questions have been answered, signatures gathered, and both forms are included in your submission. We look forward to serving you.**